PLAN DOCUMENT

NAME OF PLAN

Brookhaven Science Associates, LLC

Dental Assistance Plan

NAME, ADDRESS, AND TELEPHONE NUMBER
OF THE PLAN SPONSOR AND PLAN ADMINISTRATOR:

Brookhaven Science Associates, LLC
Brookhaven National Laboratory Building 185
P. O. Box 5000
Upton, NY 11973
(631) 344-2881

PLAN NUMBER	CONTROL NUMBER	TAX ID NUMBER
501	33005	11-3403915

PLAN EFFECTIVE DATE	PLAN YEAR
January 1, 2007	January 1 - December 31

CONTRIBUTION STATUS

Contribution is required for the employee and his or her dependent(s) to maintain coverage.

AGENT FOR SERVICE OF PROCESS

Brookhaven Science Associates, LLC
Brookhaven National Laboratory Building 185
P. O. Box 5000
Upton, NY 11973

or any officer of the corporation authorized
to receive service of legal process.

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USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice, which follows immediately and is also available from your Human Resources Department.

Neither this Plan nor your employer will use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of your employer.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U. S. Department of Health and Human Services, if you believe your rights under HIPAA have been violated.

This plan maintains a Privacy Notice, as follows, which provides a complete description of your rights under HIPAA's privacy rules. For another copy of the Privacy Notice, please contact your Human Resources Department or Medical Claims Service, Inc., (MCS). If you have questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, please contact your Human Resources Department or MCS.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Plan uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of the Plan.

How Your Health Information May be Used or Disclosed

For Treatment. The Plan may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will be recorded as it relates to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you will respond to the actions.

For Payment. The Plan may use and disclose your health information to others for purposes of receiving payment and for services that you receive. For example, a bill may be sent to you or to a third-party payor, such as an insurance company or health plan. The

information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations. The Plan may use and disclose health information about you for operational procedures. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- evaluate the performance of staff;
- assess the quality of care and outcomes in your case and similar cases;
- learn how to improve facilities and services; and
- determine how to improve the quality and effectiveness of the provided health care.

Appointments. The Plan may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest.

Required by Law. The Plan may use and disclose information about you as required by law. For example, the plan may disclose any information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their official duties.

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Research. The Plan may use your health information for research purposes when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions. Specialized government functions, such as protection of public officials or reports to various branches of the armed services, may require use or disclosure of your health information.

Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to workers' compensation.

Your Health Information Rights

You have the right to:

- request a restriction on certain uses and disclosures of your information; however, the Plan is not required to agree to a requested restriction;
- obtain a paper copy of the Notice of Privacy Practices upon request;
- inspect and obtain a copy of your health record;
- amend your health record;
- request communications of your health information by alternative means or at alternative locations;
- revoke your authorization to use or disclose health information except to the extent that action has already been taken; and
- receive an accounting of disclosures made of your health information.

Complaints

You may make a formal complaint to MCS, Attention: Privacy Compliance Officer, One Wall Street, Suite 2A, Ravenswood, WV 26164 (304) 273-5384 and/or to the Department of Health and Human Services if you believe your rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of the Plan

The Plan is required to:

- maintain the privacy of protected health information;
- provide you with this notice of its legal duties and privacy practices with respect to your health information;
- abide by the terms of this Notice;
- notify you if the Plan is unable to agree to a requested restriction on how your information is used or disclosed;
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and
- obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

The Plan reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you by e-mail and/or in hard copy within 60 days of any change.

Contact Information

If you have any questions or complaints, please contact:

Medical Claims Service, Inc.
Attention: Privacy Compliance Officer
One Wall Street, Suite 2A
Ravenswood, WV 26164
Telephone: (304) 273-5384

INTRODUCTION

Brookhaven Science Associates, LLC (the "Company") sponsors the Brookhaven Science Associates, LLC, Dental Assistance Plan (the "Plan") for its eligible employees. This is the summary plan description for the Plan in effect as of January 1, 2007. The actual plan document for the Plan consists of this summary plan description and Appendix A which contains more detailed information about Plan benefits and limitations, definitions and legal terms. If there are any inconsistencies between this summary plan description and the provisions in Appendix A, the provisions in Appendix A govern. You may obtain a copy of Appendix A from the Plan Administrator.

The Plan is self-insured. Medical Claims Service, Inc., ("MCS") provides claims administration services under the Plan. More information about Plan funding and administration is set out in "Plan Funding and Administration" on page 30.

ELIGIBILITY

Employees: You are eligible to participate in the Plan if you are an employee, partner, or proprietor, in active service at your customary place of employment and you work at least 20 hours per week for the Company. You are not eligible to participate in the Plan if you are a temporary employee or work less than 20 hours per week.

Family Members: Your eligible family members include your:

1. lawful spouse;

2. unmarried dependent child under age 19 (or to the end of the calendar year in which the child attains age 23, if your child is a full-time student in an accredited school who depends on you for main support and care. If the student graduates at a time between the limiting ages, coverage ends at the end of the calendar month in which the student graduates);

3. unmarried dependent child who is mentally or physically disabled and who cannot hold a self-supporting job due to the disability (but only if you provide MCS with proof of your child's disability (at your expense) within 31 days after your child reaches either limiting age).

4. domestic partner of the same gender, where both you and the domestic partner file a registration form with the Plan Administrator attesting to the following domestic partner criteria:

    a. You and your domestic partner must be in a committed and mutually exclusive relationship - jointly responsible for each other's welfare and financial obligations. (Mutually exclusive shall mean that neither person has had a different partner less than twelve months before completion of the Company's Affidavit of Domestic Partnership.);
    b. You and your domestic partner must exclusively reside together, with the exception of dependent children, in the same principal residence for a minimum of 12 months and intend to do so indefinitely;
    c. You and your domestic partner must not be married to anyone;
    d. You and your domestic partner must be competent to contract (18 years of age or older and mentally competent);

e. You and your domestic partner must not be blood relatives; and
f. You and your domestic partner must consider yourselves to be a family.

5. your domestic partner's dependent child(ren).

Your child means your: natural child, step-child, adopted child, child placed with you for adoption, child for whom you have been appointed legal guardian, and child recognized under a qualified medical child support order ("QMCSO"). With the exception of QMCSO children and full-time students, each child must be dependent on you for at least one-half of his or her support and care and reside with you for more than one-half of the tax year. A QMCSO child will be eligible regardless of whether he or she resides with you or receives one-half of his or her support and care from you. A full-time student is not excluded from coverage because of residence as long as they reside with you when they are not at school. Your step-child must depend on you for at least one-half of his or her support and care and reside with you.

A full-time student is a participating dependent child who is enrolled in and is regularly and physically attending an accredited college or university. For the purpose of this definition, "full-time" means a minimum of twelve semester or quarter hours, unless the school's definition of full-time attendance is less. For this purpose, school vacation (excluding a school vacation period immediately after graduation) will be considered a part of full-time school attendance. If a child leaves school during a school term, the child is covered only until the end of the calendar month in which he or she is no longer a full-time student.

If you and your spouse are both eligible to be covered under the Plan as employees, only you **or** your spouse are eligible to cover any dependent children you or your spouse may have. A family member may not be covered as a dependent of more than one employee.

WAITING PERIOD

Employees: If you were employed after the Plan's effective date, you become eligible for coverage on the first day employment. Your coverage will not be effective until you sign and date the enrollment form.

Family Members: Coverage for your eligible family member becomes effective on the date you first acquire the family member, but in no event before the date you become covered under the Plan. Your family member's coverage will not be effective until you submit an enrollment form.

If you or your family members do not enroll within 30 days of becoming eligible, you or your family members will have to wait until the next open enrollment period or, if you are eligible, you may enroll during the special enrollment period (see next section). Once enrolled, you must continue participation in the Plan until the end of the calendar year or, if earlier, your termination date.

CHANGES IN STATUS

You are permitted to modify or revoke dental coverage within 31 days of the following changes (within 60 days of the status changes denoted by an asterisk (*)):

CHANGES IN STATUS (Continued)

1. Change in legal marital status (marriage, death of spouse, divorce*, legal separation*, annulment);
2. Change in the number of dependents (birth, adoption, placement for adoption, death of a dependent);
3. Change in employment status (termination or commencement of employment of the employee, spouse or dependent (other than for misconduct));
4. Change in work schedule (an increase or decrease in the number of hours of employment by the employee, spouse, or dependent; a switch between full-time and part-time status; a strike or lockout; commencement or return from an unpaid leave of absence);
5. The dependent satisfies or ceases to satisfy the requirements for unmarried dependents (attainment of age*, student status*);
6. A change in the place of residence or work site of the employee, spouse, or dependent.

Coverage changes become effective on the date of the event and continue until the end of the calendar year or, if earlier, your termination date. If you do not make a change within the applicable period, you must wait until the next open enrollment period.

OPEN ENROLLMENT PERIOD

You and your covered family members are eligible, on a once per year basis, to enroll in this Plan. You will be notified of the open enrollment period each year. Election to enter this Plan must be made during the designated open enrollment period to become effective on January 1 immediately following the open enrollment period.

TERMINATION OF COVERAGE

Your coverage will end on the earliest of the following dates:

1. If you fail to pay a required premium by the due date, the last day of the period for which you paid the required premium;
2. The date you cease to be an eligible employee;
3. The date the Plan ceases to cover your class of employees;
4. The date the Plan terminates; and
5. The date your employer ceases to be a covered affiliate or subsidiary of the Company.

Your family member's coverage will end on the earliest of the dates:

1. If required premiums were not paid by the due date; the last day of the period for which the required premiums were paid;
2. The date you cease to be eligible for family coverage;
3. The date your family member ceases to meet the definition of eligible family member;
4. The date your family member becomes a covered employee;
5. The date the Plan ceases to provide family coverage;
6. The date the Plan terminates; and
7. (For your spouse) The date you and your covered spouse become divorced or legally separated.

TERMINATION OF COVERAGE (Continued)

If coverage ends, you or your family member may be entitled to continue coverage under federal law (also called "COBRA coverage") or under state law. See "Federal Continuation of Coverage".

TERMINATION OF DOMESTIC PARTNER COVERAGE

A domestic partnership is terminated immediately by the death of a domestic partner. Voluntary termination may be accomplished by filing a termination statement with the Plan Administrator. The statement must declare that the domestic partnership is terminated and that a copy of the termination statement has been sent certified mail to the other domestic partner's last known address. Domestic partners are not entitled to Federal Continuation of Coverage under COBRA in the event their coverage under this Plan is lost; however, Brookhaven Science Associates, LLC, has elected to offer such contination of coverage through COBRA.

REENTRY INTO PLAN AT THE END OF UNIFORMED SERVICES DUTY

Any employee (and eligible dependents of the employee) whose coverage under the Plan ended due to a period of the employee's absence for duty to the United States of America in its "Uniformed Services" for more than 31 days shall again become covered by the Plan without imposition of a waiting period as soon as the employee returns to full-time employment, provided that employee returns to, or reapplies for, reemployment within 90 days of completion of such period of duty. Uniformed Services means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in the active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Services, and any other category of persons designated by the President of the United States in time of war or emergency.

COVERAGE DURING LEAVE OF ABSENCE

If your coverage ends due to a granted leave of absence you and your eligible family members may retain your same dental coverage during the leave of absence. You are responsible for your premium for dental coverage during this time. The date the leave of absence begins will be the qualifying event date for commencement of COBRA coverage. The leave of absence period will accumulate toward your maximum COBRA coverage period.

SCHEDULE OF DENTAL BENEFITS

SERVICE	BENEFIT
Deductible per Calendar Year	$25/person; $75/family
Type I – Preventive Services	100% of scheduled amount
Type II – Basic Services	100% of scheduled amount
Type III – Major Services	100% of scheduled amount
Type IV – Orthodontia Services	50% of reasonable and customary amount
Maximum Payment per Calendar Year (Type I – Type III Services)	$1,000
Maximum Payment per Lifetime (Type IV Services)	$1,000

- **The deductible is waived for preventive (Type I) and orthodontic (Type IV) services.**
- **Any combination of covered basic (Type II) and major (Type III) expenses may be used to satisfy the deductible.**
- **The family deductible requirement will be met when three (3) covered family members each satisfy their individual deductible amount.**
- **Any dental charges applied against the deductible in the last three months of the calendar year will be credited against the deductible of the subsequent calendar year.**
- **Orthodontic (Type IV) services are available only to dependent children up to age 19. Orthodontic coverage is not provided for adults or dependent children age 19 and over.**

DENTAL EXPENSE BENEFIT FOR COVERED PERSONS

The Plan will pay the scheduled or reasonable and customary charge upon receipt of proof that you or your family member, while covered for this benefit, incurs charges for dental expenses. The amount charged for covered dental expenses listed below is subject to the applicable percentages and deductible shown in the Schedule of Dental Benefits and the Dental Limitations.

COVERED DENTAL EXPENSES

Preventive (Type I) Services

1. Oral examinations, twice per calendar year;
2. Prophylaxis (cleaning and scaling of teeth) or periodontal prophylaxis twice per calendar year;
3. Topical application of stannous fluoride, once per calendar year;
4. Bite-wing x-rays, twice per calendar year;
5. Provision of space maintainers (fixed or removable) and subsequent adjustments when required for dependent children under age 19;
6. Full mouth series of x-rays or Panorex, once every 24 months;
7. Diagnostic laboratory examinations and x-rays (other than bite-wings, full mouth, or panorex). This does not include x-rays in conjunction with orthodontia;
8. Sealants on unrestored permanent molars, once per tooth in any 36-month period for members under age 14 with a maximum payment of $20 per quadrant.

Basic (Type II) Services

1. Emergency procedures for palliative treatment of dental pain;
2. Extractions and simple alveolectomy at time of tooth extraction;
3. Oral surgical procedures;
4. Endodontic treatment, including root canal therapy;
5. Periodontal treatment;
6. Amalgam, silicate, acrylic, or composite fillings, and stainless steel crowns;
7. Relining, rebasing, or repairing of an existing appliance (fixed bridgework, removable partial, or complete dentures);
8. Local and general anesthetic required in relation to dental surgery when administered by a dentist.

Major (Type III) Services

1. Crowns and inlays, including gold and porcelain veneer filling material where other material is not suitable;
2. Crown buildups;
3. Bridge pontics, retainers, stress breakers, and dowel pins;
4. The creation of an appliance (fixed bridgework, removable partial, or complete dentures);
5. The replacement of an appliance, but only if:
   a. necessitated by the extraction of additional natural teeth while covered;
   b. necessitated because of installation of an original opposing full denture;
   c. necessitated by the extraction of additional natural teeth while covered;

d. necessitated by irreparable damage as a result of an accident while the denture is in place; or
e. the existing appliance is at least 5 years old and cannot be made serviceable.

Orthodontic (Type IV) Services

1. Formal, full-banded retention and treatment, including x-rays and other diagnostic procedures;
2. Removable or fixed appliances for tooth or bony structure guidance, retention or control of oral habits harmful to dental health.

DENTAL LIMITATIONS

The Dental Expense Benefit does not cover the following:

1. Any charges:
   a. Payable under a group medical plan, unless you are a participant in the medical programs administered by CIGNA. When dental benefits are available under one of these medical plans and also under this Plan, benefits will be coordinated so that up to 100% of allowable expenses are jointly paid by the plans. In all such cases, the medical program is primary and this Plan is secondary;
   b. Incurred for a service not reasonably necessary, or not customarily performed, for the dental care of the covered individual;
   c. Incurred for a service not furnished by dentist, unless the service is performed by a licensed dental hygienist under the supervision of a dentist or is an x-ray ordered by the dentist;
   d. Incurred for a service:
      i. Furnished by or on behalf of the United States government or any other government, unless, as to such other government, payment of the charge is legally required, or
      ii. To the extent to which any benefit in connection with such a service or charge is provided by any law or governmental program under which the individual is or could be covered.
   e. Incurred for a partial or full removable denture or fixed bridgework, or for a crown or gold restoration, involving a replacement or modification of a denture, bridgework, crown or gold restoration which was installed during the immediately preceding 5 years. (You or your family member will be given credit for the length of time covered for dental benefits under the Company's prior plan immediately prior to the effective date of this benefit, provided you or your covered family member becomes insured for this benefit on the date you or your covered family member is first eligible);
   f. Incurred for a service to a covered person which is for:
      i. An appliance, or modification of an appliance, for which an impression was made before you or your covered family member became covered, or
      ii. A crown, bridge or gold restoration, for which a tooth was prepared before you or your covered family member became covered, or
      iii. A root canal therapy, for which the pulp chamber was opened before you or your covered family member became covered, or

iv. A replacement of a tooth which was extracted before you or your covered family member became covered.

g. Incurred for covered expenses that involve subrogation, unless the covered person (or parent or legal guardian) and/or legal representatives cooperate fully with the Plan and the Plan's agents in the Plan's right to subrogate and to receive reimbursement (see "Right of Subrogation" section).

2. Any charges incurred:
   a. For a service furnished you or your family member for cosmetic purposes, unless necessitated as a result of accidental injuries sustained while you or your family member were covered;
   b. For replacement of lost or stolen appliances;
   c. For replacement of a fixed or removable prosthodontic or orthodontic appliance that has been made useless due to patient abuse, misuse, or neglect, or has been lost, stolen, or damaged.
   d. For injury arising out of or in the course of any employment for remuneration or profit, irrespective of whether covered by worker's compensation law, occupational disease law or similar legislation;
   e. For a physician or dentist for his time spent traveling, broken appointments, his transportation costs or for advice given by telephone or other means of telecommunication;
   f. For dietary planning, oral hygiene instruction, or training in preventive dental care;
   g. For oral care and supplies which are used to change vertical dimension or closure. These include, but shall not be limited to:
      i. procedures used for diagnosis,
      ii. procedures used for balance,
      iii. restoration,
      iv. fixed devices, or
      v. movable devices;
   h. For any procedure or service associated with the placement or prosthodontic restoration of a dental implant.
   i. For prescription drugs.

3. The portion of any charge for any service in excess of the reasonable and customary dental charge.

ORTHODONTIA EXPENSE BENEFIT FOR COVERED PERSONS

The Plan will pay upon receipt of proof that you or your family member, while covered for this benefit has incurred charges for covered orthodontic expense, the amount charged subject to the deductible and the percentage payable as shown in the Schedule of Dental Benefits and the limitations below.

COVERED ORTHODONTIA EXPENSES

Covered orthodontia expenses are those expenses incurred by you or your covered family member for necessary dental treatment which are not excluded below and which have as their objective the correction of malocclusion of the teeth by means of active appliances.

ORTHODONTIA LIMITATIONS

No benefit will be paid for any charges for an orthodontic procedure in connection with which an active appliance has been installed prior to the first day on which you or your family member became covered. This limitation will not apply if you or your family members were eligible for benefit payments under the group dental plan being replaced by this Plan. Benefits shall be the lesser of those under the previous group dental plan or the new coverage being provided under this Plan.

COORDINATION OF BENEFITS

If this is not your only dental insurance coverage, the benefits payable under this Plan, and any other group plan for the allowable expenses incurred during any benefit determination period will be coordinated so that the combined benefits paid or provided by all plans equal up to 100% of such allowable expenses.

You must inform us if you have other coverage (for example, through your spouse's employer); and give your consent to the release of information so that we may use this provision. You should first file your claim with the primary insurer (as shown below). When the claim is paid, send a copy of the charges and a copy of the Explanation of Benefits Statement from the first insurer to the secondary carrier (as shown below). This will expedite the processing of your claim. One of your insurance plans will be determined to be primary (using the rules below). The primary plan pays its full benefits first. The secondary plan makes payments toward the balance.

ORDER OF DETERMINATION

This Plan determines its order of benefits using the first of the following which applies:

1. General - A plan that does not coordinate with other plans is always the primary plan.
2. Non-dependent/Dependent - The benefits of the plan which covers the person as an employee, member or subscriber (other than a dependent) is the primary plan; the plan which covers the person as a dependent is the secondary plan.
3. Dependent Child/Parents Not Separated or Divorced - Except as stated in (4) below, when this Plan and another plan cover the same child as a dependent of different parents:
    a. The primary plan is the plan of the parent whose birthday (month and day) falls earlier in the year. The secondary plan is the plan of the parent whose birthday falls later in the year, but
    b. If both parents have the same birthday, the benefits of the plan which covered the parent the longer is the primary plan; the plan which covered the parent the shorter time is the secondary plan.
    c. If the other plan does not have the birthday rule, but has the gender rule and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
4. Dependent Child/Separated or Divorced Parents - If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    a. First, the plan of the parent with custody of the child;
    b. Then, the plan of the spouse of the parent with custody;
    c. Finally, the plan of the parent without custody of the child. However, if the specific terms of a court decree state that one parent is responsible for the dental care expenses of the child, then that parent's plan is the primary plan.
5. Longer/Shorter Length of Coverage - If none of the above rules determines the order of benefits, the primary plan is the plan which covered an employee, member or subscriber longer. The secondary plan is the plan which covered that person the shorter time.

The actual benefit amounts available are determined by each plan's insuring provisions. Benefits payable under this Plan will never exceed the amount which would have been paid if there were no other plans involved. If benefit payments under this Plan are reduced by coordination of benefits, only the reduced amounts will be charged against your Plan maximums.

If during coordination of benefits, payments are made in error, the insurance companies will have the right to adjust payments among themselves. Such payments satisfy the Plan's liability. If this Plan overpays a claim, the Plan will have the right to recover overpayment from any person for, to whom, or with respect to whom such payments were made, any other insurance company or any other organization.

COORDINATION WITH AUTOMOBILE INSURANCE COVERAGE

The Plan's liability for expenses arising out of an automobile accident is based on the type of automobile insurance law enacted by the state in which you reside. Currently, there are three types of state automobile insurance laws:

1. no fault automobile insurance laws;
2. financial responsibility laws; and
3. other automobile liability insurance laws.

It is the Plan's general intent not to pay dental expenses resulting from automobile accidents, and the Plan should be so interpreted.

Except as required by law, the Plan is secondary to any automobile coverage. It is not intended to reduce the level of coverage that would otherwise be available through an automobile insurance policy nor does it intend to be primary in order to reduce the premiums or costs of automobile coverage.

If you or your covered family members incur covered expenses as a result of an automobile accident (either as a driver, passenger or pedestrian), the amount of covered expenses that the Plan will pay is limited to:

1. any deductible under the automobile coverage;
2. any co-payment under the automobile coverage;
3. any expense properly excluded by the automobile coverage that is a covered expense; and
4. any expense that the Plan is required to pay by law.

FEDERAL CONTINUATION OF COVERAGE

In some circumstances, federal law requires that people who lose group dental plan coverage be given the chance to continue that coverage for a period of time. This requirement does not apply to weekly disability benefits.

A. Right to Continuation Coverage

1. You have a right to choose continuation coverage if you lose group dental plan coverage because of:

    a. a reduction in your hours of employment; or
    b. the voluntary or involuntary termination of your employment (for any reason except your gross misconduct).

2. Your spouse has the right to choose continuation coverage if he or she loses group plan coverage for any of the following reasons:

    a. your death;
    b. the termination of your employment (except as a result of your gross misconduct) or your reduction in hours;
    c. your divorce or legal separation; or
    d. your becoming entitled to Medicare.

3. Your dependent child has the right to continuation coverage if he or she loses his or her group plan coverage due to one of the four reasons described in 2. above or if he or she ceases to be an eligible dependent under the terms of the group plan. A child who is born to the covered employee or who is placed for adoption with the covered employee during a period of continuation of coverage will be considered a qualified beneficiary.

B. Length of Continuation Coverage

1. Generally

    a. If, as a result of termination of your employment or reduction in your hours, you, your spouse and/or your dependents lose group plan coverage, those of you who do lose coverage may elect continuation coverage for up to **18 months** after the date your employment terminates or hours reduce.
    b. If your spouse or dependents lose group plan coverage due to any of the other events described in A. 2. or A. 3. above (other than your employment termination or hours reduction), they may elect continuation coverage for up to **36 months** from the date they experience such event.
    c. If your spouse or dependents become entitled to continuation coverage because of termination of your employment or reduction in your hours and your spouse or dependent then experiences another of the events which would entitle such person to continued coverage, he or she may extend the 18 month continuation period to 36 months from the date of the event that first made him or her eligible for continuation coverage.

2. Extensions of Continuation Coverage

   a. Disabled Persons
   If you, your spouse or your dependents lose coverage because of termination of your employment or reduction of hours and any of you are determined under Title II or XVI of the Social Security Act to have been disabled at that time or within 60 days after continuation of coverage begins, then the disabled person may extend the continuation coverage period for the disabled person and eligible family members for **11 additional months**, provided: A notice of a Social Security determination is given to the plan administrator before the end of the initial 18 month period and within 60 days after the date of such determination. An employer may require payments of up to 150 percent of the applicable group rate for the cost of coverage for these 11 additional months.

   b. Employee's Medicare Entitlement
   If you become entitled to Medicare, regardless of whether this results in loss of your coverage under the Plan, your spouse and dependents who are entitled to continuation coverage are eligible for a continuation period of not shorter than 36 months from the date you become entitled to Medicare. This continuation period is measured from the time you are entitled to Medicare, not from the time your spouse or dependent loses coverage. The total continuation period for your spouse and dependents may actually exceed 36 months, depending on when you become entitled to Medicare.

3. If, after the occurrence of any event described in A., Right to Continuation Coverage, above, you, your spouse and/or your dependents are allowed to continue care coverage under the Plan (whether or not premium payment(s) are required) beyond the Plan's Termination of Coverage provision for any reason other than to comply with the federal law (i.e., Plan's special provisions), such continuation period(s) will be used to reduce the maximum length of continuation coverage period otherwise available to such person under this section.

C. Notification Requirements

1. If your spouse or dependent becomes eligible for continuation coverage due to divorce, legal separation or the end of dependency status, the Plan Administrator must be notified within 60 days after your spouse or dependent becomes eligible. The Plan Administrator will distribute necessary forms and explain this continuation in more detail. If the Plan Administrator is not notified within 60 days of the event that makes your spouse or dependent eligible for continuation coverage, your spouse or dependent will lose the right to such coverage.
2. In order for a disabled person continuing under the 18-month continuation coverage to be entitled to an extended continuation period of 11 additional months, such person must meet the notice requirements and all other conditions described in B. 2. a. above. A person continuing under the 11 month extended continuation coverage must notify the Plan Administrator within 30 days if the Social Security Administration determines that he or she is no longer disabled.

D. Termination of Continuation Coverage

Your employer may require you, your spouse and your dependents to pay for the cost of the continuation coverage. If these amounts are not paid within the time allowed, the continuation coverage will end.

Four other reasons that this continuation coverage may terminate before the full maximum continuation period runs out are:

1. the continued person becomes entitled to Medicare benefits;
2. the employer stops providing any group plan benefits program for employees;
3. the continued person becomes covered under another group plan, including being entitled to full coverage for conditions deemed to be pre-existing conditions under that plan (HIPAA makes a coordinating change to the COBRA rules so that if a group plan limits or excludes benefits for pre-existing conditions but because of the new HIPAA rules those limits or exclusions would not apply to (or would be satisfied by) an individual receiving COBRA continuation coverage, then the plan providing the COBRA continuation coverage can stop making the COBRA continuation coverage available);
4. with respect to a disabled person continuing under the 11 month extended continuation coverage (as described in B. 2. a. above), when the Social Security Administration determines that he or she is no longer disabled (the termination becomes effective as of the first day of the month which is at least 31 days after the Social Security Administration's determination).

F. General Information

This Federal Continuation Coverage section does not amend or change the Plan's Termination of Coverage provision. It simply provides a continuation of coverage right your employer is required to offer by law.

CONTINUATION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

During any FMLA leave, your coverage under this Plan may be continued on the same conditions as coverage provided if you had been continuously employed during the entire leave period.

You must continue your share of premiums during the FMLA leave period. The election form given to the participant must reflect that if the participant elects to continue active participation, he will be able to make these payments in any combination of the following methods at his option:

1. Advance withholding from the participant's last paycheck before any unpaid FMLA leave takes effect.
2. Withholding from any salary continuation check for a paid leave of absence that is considered as part of the participant's FMLA leave.
3. Monthly payment by the participant to the Company from the participant's own funds either at the same time as it would be made if by payroll deduction or on the same schedule as payments are made for COBRA continuation coverage.
4. Payment through any cafeteria plan under Code Section 125, if such plan makes provision for dental benefits.
5. By any other method mutually agreeable to the participant and the Company, including (where the leave is foreseeable) increased withholding from one or more of the participant's regular paychecks preceding the leave to pay in advance the required premiums during the leave.

The Company's obligation to provide ongoing coverage under this Plan for a participant on an FMLA leave ceases if the participant is more than thirty (30) days late in making a required premium payment, provided, however, that the Company may, at is option, cover a participant's missed payments so that coverage will be uninterrupted. In this event, the Company's advances may be recovered in the event the participant voluntarily terminates his or her employment under circumstances within the participant's control.

You may choose not to retain dental coverage during FMLA leave. However, when you return from the leave, benefits will be reinstated on the same terms as before the leave, without any qualifying period, physical examination, or exclusion of pre-existing conditions.

RIGHT OF SUBROGATION

If you or your covered dependent has a claim for damages or a right to recover damages from another party or parties for any illness or injury for which benefits are payable under the Plan, the Plan is subrogated to such a claim or right of recovery. The Plan's right of subrogation will be to the extent of any benefits paid or payable under the Plan, and shall include any compromise settlements. The Plan may assert this right independently of the covered person. Acceptance of benefits is constructive notice of this provision in its entirety.

If a covered person, or legal representative, estate or heir of the covered person, recovers damages, by settlement, verdict or otherwise, for an illness or injury for which a benefit has been paid under the Plan, the covered person, or legal representatives, estate or heirs of the covered person, agrees to promptly reimburse the Plan for benefits paid. The Plan's right to receive reimbursement applies to the covered person's recovery from any source, including but not limited to any party's liability and medical pay insurance, uninsured and underinsured motorist coverage, no-fault automobile coverage and Workers' Compensation coverage.

The Plan will have a first lien upon any recovery, whether by settlement, judgment, arbitration or mediation, that the covered person receives or is entitled to receive from any source, regardless of whether the covered person receives a full or partial recovery. Any settlement or recovery received shall first be deemed to be reimbursement of dental expenses paid under the Plan.

The Plan is entitled to reimbursement, even if the covered person is not made whole or fully compensated by the recovery. Any share of attorney fees or costs or common fund fees shall not reduce the Plan's recovery, unless agreed to by the Plan in writing.

If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision, regardless of whether the minor's representative has access to or control of any recovery funds.

The covered person (or parent or legal guardian) will cooperate with the Plan and the Plan's agents and help the Plan do what may be reasonably needed to protect the Plan's subrogation rights and obtain the refund. This includes furnishing all relevant information, making assignments in the Plan's favor and signing and delivering any documents needed to protect the Plan's rights. The covered person shall not take any action that prejudices the Plan's rights.

If the covered person makes a recovery from any source and fails to reimburse the Plan the lesser of:

1. the amount recovered (including amounts to be recovered through future installment payments); or
2. the amount of benefits paid related to this illness or injury,

the covered person will be personally liable to the Plan for this amount. The Plan may also offset future benefits up to the amount due to the Plan.

CLAIMS PROVISIONS

For purposes of these claims provisions, "you" means the person who is claiming benefits (you or your covered family member).

You may contact MCS to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

HOW TO FILE A CLAIM

Note: *Your provider of service may submit standardized forms (e.g., ADA) directly to MCS without the below mentioned Dental Claim Form. In most instances, this will provide enough information to process your claim for payment. If additional information is required, it will be requested. So that you and your provider will be aware of the information needed in order to process payment, the below listed instructions are provided.*

DENTAL EXPENSES:

Obtain a Dental Claim Form from your Human Resources Department or from MCS.

A Dental Claim Form should be filed for each family member. Complete the top section of the claim form, answering all the questions in full. Always include your identification number with any claims and or correspondence submitted

Mail the bill and completed claim form directly to the MCS address shown on your I. D. Card.

ADDITIONAL DENTAL EXPENSES:

Additional bills may be sent to MCS by following the below listed instructions:

Each bill or receipt must include the following information:

(a) Name of patient;
(b) Employee identification number;
(c) Name and address of the provider of the services:
(d) Date and itemization of services rendered;
(e) Diagnosis or condition being treated; and
(f) Name of the covered employee's employer.

Should you have any questions about an MCS claims payment, please contact MCS at (800) 524-0227 and ask for a customer service representative. Or, you may write to MCS at:

Eastern Benefit Systems a division of Medical Claims Service, Inc.
200 Freeway Drive, E.
East Orange, NJ 07018

CLAIMS DECISIONS

Pre-Service Claims

A pre-service claim is a request for approval of a benefit prior to obtaining care. (For example, pre-approval under utilization and review programs or a request for prior authorization of a benefit are pre-service claims.)

Decision: Pre-service claims must be decided within a maximum of 15 days at the initial level. If an extension is necessary due to matters beyond the control of the Plan, you will be notified of the circumstances before the expiration of the initial 15 day period. The claims decision will then be made no later than 15 days from the initial 15 day period.

Extension: If an extension is necessary because the necessary information to decide the claim was not submitted, you will be notified of the missing information and granted 45 days to provide the missing item(s).

Appeal: If you receive an adverse benefit determination and you appeal the decision, the review process will be initiated. The benefit determination from the review will be made within 30 days from the request for review.

Post Service Claims

Post-service claims are claims that are not classified as pre-service claims.

Decision: Post-service claims are subject to a maximum time period of 30 days at the initial level. If an extension is necessary due to matters beyond the control of the Plan, you will be notified of the circumstances before the expiration of the initial 30 day period. The claims decision will then be made no later than 15 days from the initial 30 day period.

Extension: If an extension is necessary because the necessary information to decide the claim was not submitted, you will be notified of the missing information and granted 45 days to provide the missing item(s).

Appeal: If you receive an adverse benefit determination and you appeal the decision, the review process will be initiated. The benefit determination from the review will be made within 60 days from the request for review.

Urgent Care Claims

An urgent care claim is a claim that the treating physician classifies as requiring immediate action to avoid your: severe pain; inability to regain maximum function; or jeopardy of life or health.

Decision: Urgent care claims must be decided within 72 hours.

Extension: If an extension is necessary because the necessary information to decide the claim was not submitted, you will be notified of the missing information within 24

hours of receipt of the claim and granted 48 hours to provide the missing item(s). Your claim will then be decided within 48 hours from receipt of the missing information.

Appeal: If you receive an adverse benefit determination and you appeal the decision, the review process will be initiated. The benefit determination from the review will be made within 72 hours from the request for review.

Concurrent Care Claims

A concurrent claim is a claim that involves an on-going course of treatment that has already been approved by the Plan. Any decision by the Plan to terminate or reduce benefits that have already been granted (other than by Plan amendment or termination) or that may have the potential of causing disruption to ongoing care, course of treatment, number of treatments or treatments provided as dentally necessary is considered to be an adverse benefit determination. You will be notified of the adverse benefit determination as soon as reasonably possible and granted the opportunity to appeal and obtain a decision from the review before the benefit may be reduced or terminated.

Urgent Care – Any request to extend the course of treatment beyond the period of time or number of treatments that involves Urgent Care shall be decided as soon as possible, taking into account the dental exigencies, and the Plan Administrator shall notify the claimant or his authorized representative of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours before the expiration of the prescribed period of time or number of treatments.

Appeals – An appeal of an adverse benefit determination involving Concurrent Care shall be decided and notice issued to the claimant or his authorized representative as soon as possible, but in no event later than seventy-two (72) hours after the Plan Administrator has received the request for the review on appeal, if the claim involves Urgent Care. The relevant time for determination is thirty (30) days, in the case of a Pre-Service Claim, and sixty (60) days, in the case of a Post-Service Claim.

PROOF OF LOSS

Written proof of loss must be furnished to MCS within 90 days after the date of loss for which the claim is made. Failure to furnish written proof of loss within that time will not invalidate or reduce any claim if you can prove that it was not reasonably possible to furnish written proof of loss within that time (as long as you furnish proof of loss as soon as reasonably possible and (unless you are legally incapable) within one year from the time proof is otherwise required).

INCOMPLETE CLAIMS/NOTICE DISCLOSURE REQUIREMENT

If your filed claim is incomplete, you will be notified as soon as possible but no later than 5 days (24 hours for urgent care claims) following the failure to follow the proper procedures for filing a claim for benefits. This notice will also include the steps necessary to cure the defect in the claims filing.

ADVERSE BENEFIT DETERMINATIONS

If your request for payment or reimbursement is adversely determined, you will receive notice from MCS within the time frames listed above (see Claims Decisions), based on the type of claim submitted. If special circumstances require an extension of time for processing, you will be notified of the reasons for the delay.

The notice of adverse benefit determination will include:

1. the specific reason or reasons for the adverse benefit determination;
2. reference to the Plan provision(s) on which the adverse benefit determination is based;
3. a description of any additional material or information necessary to complete the claim and the reason why the material or information is necessary;
4. a description of review procedures incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review;
5. a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;
6. If the adverse benefit determination was based on an internal rule, guideline, protocol or other similar criterion, the specific rule, guideline, protocol or criterion will be provided free of charge, upon request;
7. If the adverse benefit determination was based on the dental necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your dental circumstances, will be provided free of charge, upon request.

APPEALS

You or your authorized representative may appeal an adversely determined claim within 180 days after you receive the notice of adverse determination. You or your authorized representative has the right to:

1. submit a request for review, in writing (orally, if an urgent care claim), to MCS;
2. reasonable access, upon request and free of charge, to and copies of all documents, records and other information relevant to the claim; and
3. submit issues and comments in writing to MCS.

MCS will notify you in writing of its decision, after it receives your written request for review, within the time frames listed above (see Claims Decisions). If special circumstances require an extension of time for processing, you will be notified of the reasons for the delay and the date you may expect a final decision.

The review will not afford deference to the initial adverse benefit determination and will be conducted by a party who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a dental judgment, including determination whether a particular treatment, drug or other item is experimental, investigational or not dentally necessary or appropriate, a dental care professional who was not involved in the original benefit determination will be consulted. This dental care professional will have appropriate training and experience in the field of medicine involved in the dental judgment. Dental or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

MCS shall provide you or your authorized representative with written or electronic notice of the Plan's benefit determination on review in accordance with the applicable time frames set forth above. In the case of an adverse benefit determination, the notice shall set forth, in a manner calculated to be understood by you:

a. the specific reason or reasons for the adverse determination;
b. reference to the specific Plan provisions on which the benefit determination is based;
c. a statement that you are entitled to receive without charge reasonable access to any document (1) relied on in making the determination, (2) submitted, considered or generated in the course of making the benefit determination, (3) that demonstrated compliance with the administrative processes and safeguards required in making the determination, or (4) that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;
d. if the adverse determination is based on dental necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to your dental condition, or a statement that this will be provided without charge on request;
e. a statement describing the Plan's optional appeals procedures, including the provision for optional arbitration and your right to receive information about the procedures as well as your right to bring civil action under ERISA §502(a); and
f. the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

After exhaustion of the claims procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available except to the extent any such person has agreed to binding arbitration.

OPTIONAL ARBITRATION

Any controversy or claim made on or after the effective date of this Plan arising out of or relating to a claim for benefits payable by the Plan shall, at the option of the claimant, be settled by arbitration in accordance with the Employee Benefit Plan Claims Arbitration Rules of the American Arbitration Association, which are incorporated into this Plan by reference. In this connection, the Plan Administrator shall make a copy of these rules available for inspection by any concerned person or his authorized representative during normal business hours.

The Plan may not be required to submit any such claim or controversy to arbitration until the claimant has first exhausted the Plan's internal claim review and appeals procedures set forth

above, although the Plan Administrator may voluntarily do so at any point in processing an appeal from a prior claim denial or other disputed benefit determination.

The Company will bear all costs of an arbitration, except that the arbitrator shall have the power to apportion among the parties other expenses such as pre-hearing discovery, travel costs and attorneys' fees.

The decision of the arbitrator shall be final and binding on all parties, and judgment on the arbitrator's award may be entered in any court of competent jurisdiction.

PAYMENT OF CLAIMS

Benefits will be payable to the service provider unless MCS is notified in writing that the service provider has already been paid by you or you submit a separate authorization to MCS. Any benefits you are due will be paid. Any payment made will discharge the Plan from further liability to the extent payment is made. All benefits will be paid after receipt of proof. The covered person will, upon request from MCS, provide all information and sign and return all documents as required by MCS for the processing of payment under this Plan.

If you or your family members die while benefits provided for hospital, nursing, dental or surgical services remain unpaid, the Plan may pay the individual or institution on whose charges claims are based or your spouse or surviving child or children or the executors or administrators of your or your family member's estate.

If your family member is a minor or, in the Plan Administrator's opinion, incompetent, and the Plan Administrator does not receive a request for payment from a duly appointed legal guardian or legally appointed representative, the Plan may pay the individual or institution appearing to the Plan to have assumed the custody or principal support of that person.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

LEGAL ACTION

Except as otherwise required by applicable law, any action at law or equity must be brought to recover benefits under the Plan within 2 years from the time when proof of loss is required. Before legal or equitable action may be brought, your claim must be filed and appealed under the Plan as stated above.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan Administrator, at its own expense, may have you examined, when and as often as it may reasonably require during the time a claim is pending and to have an autopsy performed in the case of your death, by a licensed physician where it is not forbidden by law or your religious affiliation.

MISSTATEMENT OF AGE

If your age has been misstated, the benefits payable under the Plan will be based on your true age.

OTHER IMPORTANT INFORMATION

PLAN FUNDING AND ADMINISTRATION

The Plan Administrator is the Company (Brookhaven Science Associates, LLC). The name, address and telephone number of the Agent for Service of Process is listed on page 1. The Plan is a self-insured group dental plan. Funding is derived from the funds of the Company and contributions made by covered employees, if contribution is required. The level of contribution, if any, is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of or require employee contribution. The Plan Administrator serves without compensation. However, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan. The Plan Administrator shall constitute the "named fiduciary" and the "administrator" with respect to the Plan as such terms are defined in ERISA, and in such capacities it shall have authority to control and manage the operation and administration of the Plan. The Plan Administrator shall have the powers and duties specified in the Plan, including the discretionary authority to interpret the provisions of the Plan and to determine all questions relating to eligibility for benefits hereunder. Any such interpretation or determination adopted by the Plan Administrator in good faith shall be binding upon the Company and on all participants, former participants and beneficiaries. The Plan Administrator, in exercising its discretion shall do so in a uniform and non-discriminatory manner, treating all individuals in similar circumstances alike.

MCS provides claims administration services under the Plan. Benefits are paid from the Plan through the Claims Administrator. MCS is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

The name, address and telephone numbers of MCS are: Medical Claims Service, Inc., One Wall Street, Suite 2A, Ravenswood, WV 26164-1714, (304) 273-5918, (888) 225-0522.

AMENDMENT

The Company shall have the right to amend this Plan in any and all respects at any time, and from time to time, without prior notice to any participant or eligible dependent; provided, however, that no amendment: (1) shall increase the duties and liabilities of the Plan Administrator without the Administrator's written consent, nor increase the duties and liabilities of the trustees of the related dental benefits trust (if any) without the written consent of the trustees; or (2) shall divert Plan funds or assets (if any) from the exclusive purpose of paying for the benefits provided by the Plan for or on behalf of the participants and their eligible dependents.

Any such amendment shall be by a written resolution of a majority of the Board of Directors of the Company or other governing body and shall become effective as of the date specified in the enabling resolution. A certified copy of any amendment shall be furnished to the Plan Administrator, the trustees and to any outside provider of the plan administration services.

The Plan Administrator shall notify all covered participants of any amendment modifying the substantive terms of the Plan as soon as is administratively feasible after its adoption, but in no event later than 210 days after the close of the Plan Year in which the amendment has been adopted. Such notification shall be in the form of a summary of material modifications (within the meaning of ERISA §102(a)(1) and Labor Reg. §2520.104b-3) unless incorporated in an updated summary plan description (as described in ERISA §102(b)).

TERMINATION

Regardless of any other provision of this Plan, the Company necessarily reserves the right to terminate this Plan with respect to any and all participants and eligible dependents at any time without prior notice. Such termination shall be evidenced by a written resolution of a majority of the Board of Directors of the Company or other governing body, a certified copy of which shall be filed with the Plan Administrator, the trustees, and any outside provider of plan administration services.

The Plan Administrator shall notify all participants and eligible dependents covered under this Plan of its termination as soon as is administratively feasible, but no more than 210 days after the last day of the final plan year.

This Plan shall automatically terminate if the Company: (1) is legally dissolved; (2) makes any general assignment for the benefit of its creditors; (3) files for liquidation under the Bankruptcy Code; (4) merges or consolidates with any other entity and it is not the surviving entity; (5) sells or transfers substantially all of its assets; or (6) goes out of business, unless the Company's successor in interest agrees to assume the liabilities under this Plan as to the participants and eligible dependents.

NO RIGHT OF EMPLOYMENT

The Plan is not an employment contract. The Plan does not give you the right to employment with the Company and does not in any way prevent the Company from terminating your employment.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If MCS receives a medical child support order (including a court order, settlement agreement or administrative decree) involving you or your covered family member, it will notify you and each alternate recipient under the order. MCS will determine whether the order is a qualified medical child support order ("QMCSO") and will notify you and each alternate recipient of its determination. If an order is determined to be a QMCSO, the alternate recipients under the QMCSO will be considered to be participants in the Plan to the extent required in the QMCSO. You may obtain, without charge, a copy of the procedures governing qualified medical child support order determinations from MCS.

HIPAA – USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A. Use and Disclosure of Protected Health Information (PHI)

The Plan will use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 "HIPAA"). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that related to an

individual to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefits claims;
- establishing employee contributions;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;
- utilization review, including pre-certification, pre-authorization, concurrent review and retrospective review;
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, identification number, payment history, account number and name and address of the provider and/or health plan); and
- reimbursement to the Plan.

Health Care Operations include, but are not limited to, the following activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
- underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance or risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- business planning and development such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development or improvement of payment methods or coverage policies;
- business management and general administrative activities of the Plan, including, but not limited to:
  (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or

(b) customer service, including the provision or data analyses or policyholders, plan sponsors or other customers;

- resolution of internal grievances; and
- due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

B. The Plan will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary

With an authorization, the Plan will disclose PHI to pension plans, disability plans, reciprocal benefit plans, and workers' compensation insurers, for purposes related to administration of this Plan.

C. For Purposes of This Section The Employer Is the Plan Sponsor

This Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions.

D. With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions

The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- report to Health Plan's designee any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provided for;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;
- ensure that adequate separation between the Health Plan and the Plan Sponsor is established as required by HIPAA (45 CFR 164.504 (f) (2) (iii)); and
- if feasible, return or destroy all PHI received from the plan that the Plan Sponsor maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

E. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, only designated individual(s) (e.g., Vice President for Human Resources, Director of Compensation and Benefits, etc.) or a class of individuals designated by the aforementioned designator(s) may be given access to PHI.

F. Limitations of PHI Access and Disclosure

The persons described in Section E may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan.

G. Noncompliance Issues

If the persons described in Section E do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of non-compliance, including disciplinary sanctions.

ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue dental care coverage for yourself, your spouse or dependents, if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan or the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan issuer: when you lose coverage under the Plan; when you become entitled to elect COBRA continuation coverage; when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion period after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who pays court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor (see below) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue, N. W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

EBSA FIELD OFFICES		
New York Regional Office Frank Clisham, Director 201 Varick Street New York, NY 10014 Tel: (212) 337-2228	Washington Regional Office Mabel Capolongo, Director S1335 East-West Highway, Suite 200 Silver Springs, MD 20910 Tel: (301) 713-2000 Fax: (301) 713-2008	Atlanta Regional Office Howard Marsh, Director 61 Forsyth St., SW., Suite 7B54 Atlanta, GA 30303 Tel: (404) 562-2156 Fax (404) 562-2168
Los Angeles Regional Office Bill Beaver, Director 1055 East Colorado Blvd., Suite 200 Pasadena, CA 91106-2341 Tel: (626) 229-1000 Fax: (626) 229-1098	Miami District Office Jesse Day, Supervisor 8040 Peters Road Building H, Suite 104 Plantation, FL 33324 Tel: (954) 424-4022 Fax: (954) 424-0548	San Francisco Regional Office Bette Briggs, Director 71 Stevenson St., Suite 915 San Francisco, CA 94105 Tel: (415) 975-4600 Fax: (415) 975-4589
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Kansas City Regional Office Gregory Egan, Director City Center Square 1100 Maine, Suite 1200 Kansas City, MO 64105-2112 Tel: (816) 426-5131 Fax: (816) 426-5511	St. Louis District Office Gary Newman, Supervisor Robert A. Young Federal Building 1222 Spruce Street, Room 6310 St. Louis, MO 63103 Tel: (314) 539-2693 Fax: (314) 539-2697	Dallas Regional Office Bruce Ruud, Director 525 Griffin Street, Room 707 Dallas, TX 75202-5025 Tel: (214) 767-6831 Fax: (214) 767-1055
Boston Regional Office James Benages, Director J. F. K. Building, Room 575 Boston, MA 02203 Tel: (617) 565-9600 Fax: (617) 565-9666	Chicago Regional Office Kenneth Bazar, Director 200 West Adams Street, Suite 1600 Chicago, IL 60606 Tel: (312) 353-0900 Fax: (312) 353-1023	Philadelphia District Office Steven Schwab, Associate Director The Curtis Center, Suite 870 West 170 S. Independence Mall West Philadelphia, PA 19106 Tel: (215) 861-5300 Fax: (215) 861-5347

GENERAL PROVISIONS

COMPANY FUNDING - All benefits paid under this Plan shall be paid in cash from the general assets of the Company. No employees shall have the right, title, or interest whatever in or to any investment reserves, accounts or funds that the Company may purchase, establish or accumulate to aid in providing benefits under this Plan. Nothing contained in this Plan, and no action taken under its provisions, shall create a trust or fiduciary relationship of any kind between the Company and an employee or any other person. Neither an employee nor a beneficiary of an employee shall acquire any interest greater than that of an unsecured creditor.

IN GENERAL – Any and all rights accruing to any person under this Plan shall be subject to the terms and conditions of the Plan and the related trust agreement, if any. This Plan shall not constitute a contract between the Company and any participant or eligible dependent nor shall it be consideration or an inducement for the initial or continued employment of any employee. Likewise, maintenance of this Plan shall not be construed to give any participant the right to be retained as an employee by the Company or the right to any benefits not specifically provided by the Plan.

WAIVER AND ESTOPPEL – No term, condition or provision of this Plan shall be deemed waived, and there shall be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No participant or eligible beneficiary other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

EFFECT ON OTHER BENEFIT PLANS – Amounts credited or paid under this Plan shall not be considered to be compensation for the purposes of any qualified pension plan maintained by the Company. The treatment of the amounts paid under other employee benefit plans shall be determined under the provision of the applicable employee benefit plan.

NONVESTED BENEFITS – Nothing in this Plan shall be construed as creating any vested rights to benefits in favor of any participant or eligible dependent except with respect to claims that have actually been incurred by any such person that would otherwise be eligible for payment under the Plan, as it is in effect when the expense is incurred.

INTERESTS NOT TRANSFERABLE – The interests of the participants and their eligible dependents under this Plan are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, assigned, alienated or encumbered.

GENDER AND NUMBER – Except when otherwise indicated by the context, words in the masculine gender shall include the feminine and neuter genders, the plural shall include the singular, and the singular shall include the plural.

SEVERABILITY – If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. The Company shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

HEADINGS – All article and section headings in this Plan have been inserted for convenience only and shall not determine the meaning of the content thereof.

APPLICABLE LAW – This Plan is fully exempt from Titles II, III and IV of ERISA. The Plan shall be governed and construed in accordance with Title I of ERISA and the laws of the State where the Plan is domiciled to the extent not preempted by ERISA.

APPENDIX A

OTHER:

RIGHT OF SUBROGATION

If you or your covered dependent has a claim for damages or a right to recover damages from another party or parties for any illness or injury for which benefits are payable under the Plan, the Plan is subrogated to such a claim or right of recovery. The Plan's right of subrogation will be to the extent of any benefits paid or payable under the Plan, and shall include any compromise settlements. The Plan may assert this right independently of the covered person. Acceptance of benefits is constructive notice of this provision in its entirety.

If a covered person, or legal representative, estate or heir of the covered person, recovers damages, by settlement, verdict or otherwise, for an illness or injury for which a benefit has been paid under the Plan, the covered person, or legal representatives, estate or heirs of the covered person, agrees to promptly reimburse the Plan for benefits paid. The Plan's right to receive reimbursement applies to the covered person's recovery from any source, including but not limited to any party's liability and medical pay insurance, uninsured and underinsured motorist coverage, no-fault automobile coverage and Workers' Compensation coverage.

The Plan will have a first lien upon any recovery, whether by settlement, judgment, arbitration or mediation, that the covered person receives or is entitled to receive from any source, regardless of whether the covered person receives a full or partial recovery. Any settlement or recovery received shall first be deemed to be reimbursement of dental expenses paid under the Plan.

The Plan is entitled to reimbursement, even if the covered person is not made whole or fully compensated by the recovery. Any share of attorney fees or costs or common fund fees shall not reduce the Plan's recovery, unless agreed to by the Plan in writing.

If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision, regardless of whether the minor's representative has access to or control of any recovery funds.

The covered person (or parent or legal guardian) will cooperate with the Plan and the Plan's agents and help the Plan do what may be reasonably needed to protect the Plan's subrogation rights and obtain the refund. This includes furnishing all relevant information, making assignments in the Plan's favor and signing and delivering any documents needed to protect the Plan's rights. The covered person shall not take any action that prejudices the Plan's rights.

If the covered person makes a recovery from any source and fails to reimburse the Plan the lesser of:

1. the amount recovered (including amounts to be recovered through future installment payments); or
2. the amount of benefits paid related to this illness or injury,

the covered person will be personally liable to the Plan for this amount. The Plan may also offset future benefits up to the amount due to the Plan.

DEFINITIONS:

When these terms are used in this Plan, they will have the following meanings unless otherwise noted:

ACCIDENT

A bodily injury sustained independently of all other causes, that is sudden, direct and unforeseen and is exact as to time and place.

ACTIVE SERVICE

An employee will be considered to be in active service on any day he performs in the customary manner all of the regular duties of his employment. An employee shall be deemed in active service on each day of a regular paid vacation, on each day of earned or accumulated fringe benefits (e.g., sick days, personal days, bereavement leave days, etc.) provided by the Company or on a regular non-working day on which he is not totally disabled, provided he is in active service on the last preceding regular working day. Earned or accumulated fringe benefits must be documented by the Company. This documentation must be made available to MCS upon request.

ASSOCIATED COMPANY

The employer's subsidiary, parent or affiliated entity, if any, which is shown on page 1.

BENEFIT

The amount paid for covered expenses after meeting the deductible, if deductible is applicable.

COMPANY

The Employer to which this Plan applies as shown on page 1.

COSMETIC PROCEDURE

The term "cosmetic procedure" means a procedure performed solely for improved appearance of the Covered Person rather than for the improvement or restoration of bodily function.

COVERED CHARGES

Means those charges actually made to a covered person for the treatment of an illness or injury subject to any limitations and exclusions.

COVERED EXPENSE

A listed expense under a benefit description which will be paid under this Plan if it is:

a. prescribed by a dentist for the therapeutic treatment;
b. dentally necessary;
c. not more than what is determined as reasonable and customary; or
d. not excluded under any exceptions of the Plan.

If a participating provider is used, covered expense means the agreed upon rate set between the Plan Administrator and such provider for dental services which meets all of the above requirements. Covered expenses will also include the reasonable cost of negotiation realized by the Plan and Medical Claims Service, Inc.

COVERED PERSON

An enrolled person meeting the eligibility requirements of this Plan.

DENTIST

A person licensed to practice dentistry by the appropriate authority in the area where the dental service is given.

EMPLOYER

The entity to which the Plan is issued including any Associated Companies shown on page 1.

EXPENSE INCURRED

Each expense is considered to be incurred on the date the care, service or supply is received.

EXPERIMENTAL

Any treatment, procedure, facility, equipment, drug or drug usage, device or supply not accepted as standard treatment of the condition being treated by the general dental community, or any such items requiring Federal or other governmental agency approval not granted at the time services were rendered. Such agencies include but are not limited to the American Medical Association and/or the Federal Drug Administration.

FULL-TIME EMPLOYMENT

Full-time employment is a basis whereby an Employee is employed by the Company for a minimum of twenty (20) hours per week. Such work may occur either at the usual place of business of the Company or at a location to which the business of the company requires the Employee to travel for which he receives regular earnings from the Company.

FULL-TIME STUDENT

A full-time student is a participating dependent child who is enrolled in and is regularly and physically attending an accredited college, university, vocational or technical school with a regular teaching staff, curriculum and student body. For the purpose of this definition, "full-time" means a minimum of twelve semester or quarter hours, unless the school's definition of full-time attendance is less. For vocational and technical school, the definition of full-time attendance must be provided by the school itself. For this purpose, school vacation (excluding a school vacation period immediately after graduation) will be considered a part of full-time school attendance. If a child leaves school during a school term, the child is covered only until the end of the calendar month in which he or she is no longer a full-time student.

ILLNESS

Sickness, a covered bodily or mental infirmity or pregnancy.

INJURY

A covered accidental bodily injury which results in damage to body of the Covered Person from an external force.

MONTH

Means a period of time beginning with a date and terminating on the same date of the succeeding calendar month. If the succeeding month has no such date, the last day of that month will be used.

NAMED FIDUCIARY

Means any person (including a corporation) who:

(a) Exercises any discretionary authority or discretionary control over the management of the Plan or exercises any authority or control over the management or disposition of its assets;
(b) Gives investment advice for compensation or has the authority or responsibility for doing so; or
(c) Has any discretionary authority or responsibility in administering a plan.

PRONOUNS

Masculine pronouns used in the Plan Document will apply equally to both male and female persons.

REASONABLE CHARGE

An amount measured and determined by comparing the actual charge with the charges customarily made for similar services and supplies to individuals of similar dental condition in the locality concerned. Determination of the reasonable charge will be made by the Claims Administrator based on nationally obtained and recognized survey data or data received from an insurance company which is involved in the adjudication of care claims.

TREATMENT PLAN

Means a dentist's report on a form satisfactory to the Employer which:

(a) Itemizes the dental services recommended by him for the necessary dental care of a covered person;
(b) Shows his charges for each dental service; and
(c) Is accompanied by supporting pre-operative x-rays where required or requested by the Employer.